



Glasgow Housing
Register · Northwest

Medical Form



Charing Cross Housing Association Ltd





To ensure this form does not get separated from the Main Application, please provide the Main Applicant's name and contact details, along with the name of anyone included in your application who has a health problem or disability that may be eased by moving to a more suitable home.

The information requested below will help assess any care, support or medical needs within your household and to identify the most suitable housing. You may be required to provide evidence of any care and support needs.

Main Applicant

Title

Mr

Mrs

Ms

Miss

Other

If other, please give details

First Name

Middle Names

Last Name/Family Name(s)

Address

Line 1

Line 2

City

Postcode

Contact Phone No

Work Phone No

Mobile Phone No

email address

Person with Health Problem/Disability

Name	Date of Birth
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Please explain briefly the health problem or disability and how long the problem has existed.

Health Condition

How long have you/they had this health problem?

Disability

How long have you/they had this health problem?

Tell us why you feel a move to another property will help. Please note, medical points are normally awarded if your/their condition would benefit from a move to a different property.

Do you, or anyone living with you, need any of the following?

A link to an emergency call system	<input type="checkbox"/>
Accommodation all on one level	<input type="checkbox"/>
An extra bedroom for medical reasons	<input type="checkbox"/>
Ground floor accommodation	<input type="checkbox"/>
Special adaptations to your home	<input type="checkbox"/>
Wheelchair access	<input type="checkbox"/>
Anything else for medical reasons	<input type="checkbox"/>

Do you/they receive Support from a friend or relative?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please provide details of the name and address of the friend/relative and the support received			
Name			
Current Address			
Line 1		Line 2	
City		Postcode	
Support received			
Do you/they have any difficulty walking?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your/their current home wheelchair adapted?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you/they have difficulty with stairs either inside or outside the home?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your/their home have internal stairs?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, how many?			
Does your/their home have external stairs?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, how many?			
Are there any adaptations made to your/their home?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please provide details			
Does your/their home need further adaptations?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, please provide details			

Does your/their home have dampness?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes, and this affects your/their health, please provide details below					
What type of heating is currently in your/their home?					
		Electric	<input type="checkbox"/>		
		Gas	<input type="checkbox"/>		
		None	<input type="checkbox"/>		
		Other	<input type="checkbox"/>		
		Solid Fuel	<input type="checkbox"/>		
What type of heating would you/they prefer?					
		Electric	<input type="checkbox"/>		
		Gas	<input type="checkbox"/>		
		None	<input type="checkbox"/>		
		No Preference	<input type="checkbox"/>		
		Solid Fuel	<input type="checkbox"/>		
If the present heating system causes you/them health problems, please provide brief details					
Does the person being assessed have difficulty with any of the following?					
	No Difficulty	Some Difficulty	Great Difficulty	Assistance Required	
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting in and out of bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting on/off the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting dressed and undressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If you/they have a garden, can you/they maintain it?	
Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
No Garden	<input type="checkbox"/>
Please provide the name and address of your/their doctor and that of any other health care professional with who you/they have had recent contact. We may need to contact them. Doctor's name, address and telephone number:	
Name	
Address	
Line 1	Line 2
City	Postcode
Phone No.	
Is there another doctor or health care professional who we can contact?	
Name	
Address	
Line 1	Line 2
City	Postcode
Phone No.	
Do we have the permission of those claiming a care/support/medical condition or disability to contact any of the above health care professionals if we need more information regarding the applicant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
I hereby authorise the landlord(s) to whom I am applying to seek any further information they may require regarding the medical condition/disability from the above named health professional(s) to fully assess the housing application.	
I understand this information will be used solely for the purpose of assessing my housing application and may be shared by other landlords within the Glasgow Housing Register North West with whom I have expressed an interest.	
Signature	
Date	
For a child under 16 years of age we require the confirmation of parent / guardian or other authorised person.	
Signature	
Date	